

Davenport SJ (2021) Impact of occupational therapy in an integrated adult social care service: Audit of Therapy Outcome Measure Findings. Journal of Integrated Care Available at

<https://www.emerald.com/insight/content/doi/10.1108/JICA-04-2021-0020/full/html>

Accessed 03/12/21

Title: Impact of occupational therapy in an integrated adult social care service: Audit of Therapy Outcome Measure Findings.

Abstract

Purpose Health and social care services should demonstrate the quality of their interventions for commissioners, patients, and carers, plus it is a requirement for occupational therapists to measure and record outcomes. Use of the “Therapy Outcome Measure” standardised tool was implemented by an occupational therapy adult social care service to demonstrate outcomes from April 2020, following integration to a community NHS Trust.

Design The aim was to demonstrate occupational therapy outcomes in adult social care through a local audit of the Therapy Outcome Measure. The objective was to determine if clients improved following occupational therapy intervention in the four domains of impairment, activity, participation and wellbeing/carer wellbeing. 70 cases were purposively sampled over a 2-month timeframe, extracting data from the local electronic recording system.

Findings Occupational therapy in adult social care clearly makes an impact with their client group and carers. Evidence from the dataset demonstrates clinically significant change, as 93% of clients seen by adult social care occupational therapy staff showed an improvement in at least one therapy outcome measure domain during their whole episode of care. 79% of activity scores, 20% of participation scores and 50% of wellbeing scores improved following intervention. 79% of carer wellbeing scores improved following occupational therapy.

Originality

Introduction Evidence of health service quality is essential in today's health and social care economy (Health and Social Care Act 2012, Francis, 2013) for accountability and quality improvement. Allied health professionals (AHPs), nurses and other clinicians must report on the effectiveness of their interventions to demonstrate impact (Health and Care Professions Council (HCPC) 2018; Pearson, 2017; Caldwell *et al.*, 2015). Outcome measures can be used to demonstrate client progress and effectiveness of services (Unsworth, 2000), plus data can assist purchasers of services across health and social care commissioning (Enderby *et al.*, 2003) to identify effective services. Medical and social care outcomes differ; medical indicators are concerned with disease, whereas social care focusses on a wider holistic measure of health relating to overall quality of life and maintenance (Dickinson and O'Flynn 2016).

Integrated health and social care services aim to promote better co-ordination of services and continuity of care (Coughlan *et al.*, 2020); but brings its own challenges as professionals from various backgrounds have different philosophies and values (Peck *et al.*, 2001). Health and social care providers hold different legal, budgetary and accountability frameworks and geographical boundaries may differ (Glasby 2017), although overlapping values exist (Shand and Turner (2019).

Use of outcome measures is well documented in occupational therapy, furthermore it is a requirement for occupational therapists to measure and record outcomes (Royal College of Occupational Therapists (RCOT) 2015). The new professional standards for occupational therapy practice, conduct and ethics from RCOT state "Use outcome measures to monitor, review and demonstrate the ongoing effectiveness of intervention" (RCOT, 2021 p.16). A standardised outcome measure has a set and unchanging procedure (RCOT 2015), used by therapists to identify an improvement in client's function or occupational performance (Laver Fawcett, 2007) to determine if the desired therapeutic outcomes have been achieved. This paper describes findings from the Therapy Outcome Measure (Enderby and John, 2015) to illustrate occupational therapy outcomes in adult social care through a quality improvement audit.

Context

Occupational therapists, plus support practitioners working for the adult social care service covering Wirral local authority were integrated into Wirral Community Health and Care NHS Foundation Trust (WCHC) in 2017. The adult social care occupational therapy service comprises major adaptations, short term assessment and reablement (STAR), Wirral independence service (Equipment), adult social care team and blue badge independent mobility assessors. The referral criteria for adult social care includes any adult over the age of 18 who appears to require care and support under the Care Act (Department of Health and Social Care (DHSC) 2014). Occupational therapy within adult social care delivers interventions to a wide range of adults, often with chronic conditions which impact on their occupational performance. Occupational interventions are aimed at maintaining safety in essential activities of daily living (ADL), for example, falls prevention, moving and handling solutions such as hoist and specialist sling provision or bed mobility solutions, major adaptations for example level access shower, stairlifts, through floor lifts and ramping, specialist seating provision and liaison with local housing services, plus “low level” ADL equipment and reviews for levels of care packages. Interventions can consist of telephone advice, or one or more visits depending on complexity. Cases can remain on caseloads from approximately one week to more than 3 months. Adult social care is not a rehabilitation or intermediate care service; however, these specialisms are provided by the Trust. The Therapy Outcome Measure (Enderby and John 2015) was already in use across AHP services within the Trust upon integration to measure outcomes. Prior to integration the local adult social care approach to quality improvement was informal, utilising referral and waiting list data and qualitative client/carer feedback. The author initiated implementation of the Therapy Outcome Measure as part of post graduate studies. The measure was accepted by the adult social care service in 2018 as a new service development, and as part of the integration agenda with the Trust. Staff were trained and the measure was adopted for mandatory electronic recording by occupational therapy practitioners from April 2020.

Therapy Outcome Measure (Enderby and John 2015)

The Therapy Outcome Measure (TOM) is a standardized therapist reported tool, used to measure and record outcomes in client care. It enables professionals from different disciplines in health and social care to measure the difficulties and abilities

of their users. The tool measures 4 domains of a person's life before and after intervention by the professional; impairment, activity, participation and wellbeing of client/carer. These domains are based on the description from the World Health Organisation's International Code of Classification of Disability and Function (WHO, ICF 2001).

Scoring is completed using one of a range of "adapted scales", which align to the client's main medical diagnosis. 50 adapted scales are available for scoring with another 17 in development (Enderby and John 2019). The authors have also developed the "Core Scale" for assessors to utilise in situations where the diagnosis is unclear or to use alongside an adapted scale to support decision-making, or where an adapted scale is not available or is inappropriate (Enderby and John, 2019).

Scoring is completed at initial assessment and at close of occupational therapy provision, to provide two scores. An intermediate score can also be made although this is not utilised locally. The domains are scored from zero (profound) up to 5 (high/normal) on an 11-point ordinal scale (Table 1) with use of 0.5 markers. Ordinal variables are rank ordered, but the distances across categories are not equal within the scale (Bryman, 2008). Zero represents a profound score with five representing normal according to age, sex and culture (Enderby and John, 2015). The integers are defined with semantic operational code descriptors on the "adapted scales" to classify the severity of the difficulty. The 0.5 markers are not defined, allowing the assessor to judge if their client is slightly better or worse than the descriptor level. For the TOM, the measure of clinically significant change is set at 0.5 (Enderby and John, 2019).

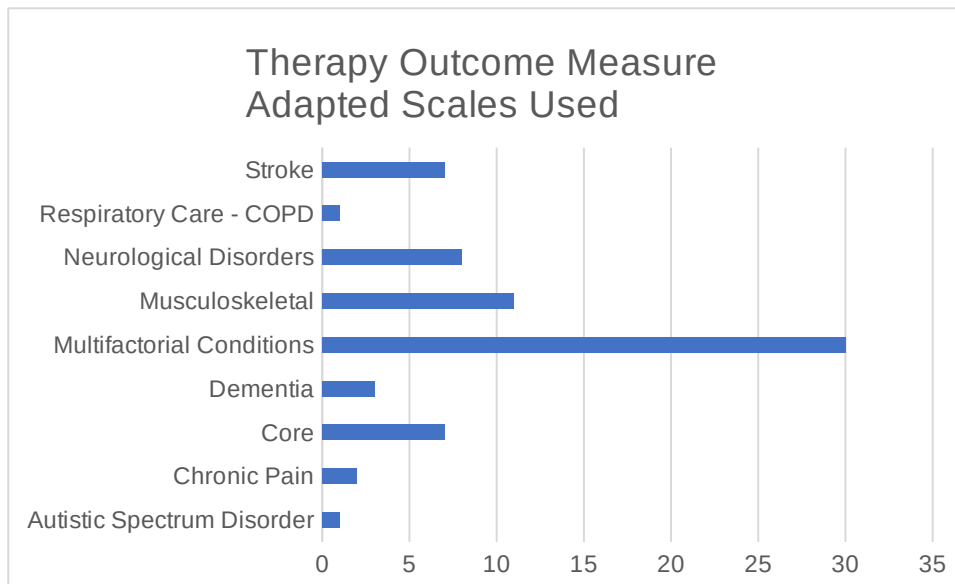


Figure 1 Adapted Scales Used

Using the ordinal scale, the rank order is inferred but not the relative size (Whittaker and Williamson, 2011), for example a client who is scored to be 4 (mild) is not necessarily twice as able as a person who is scored 2 (severe/moderate) on the ordinal scale.

Methods

Audit aim and objectives

Audit is well recognised as a pillar of clinical governance in the NHS (Buth and D'Cruz, 2012), providing a quality improvement process that seeks to improve patient care and outcomes through systematic critical analysis (Bowling, 2009). For this adult social care setting within the NHS, the need to audit is underpinned by High Quality Care for All (DHSC 2008) and provides evidence for on-going inspection from the independent regulator Care Quality Commission (CQC) to ensure services are effective. Audit is further reinforced by NICE (National Institute for Clinical Excellence) (2021) pathway: Peoples Experience in Adult Social Care Services, which suggests practitioners learn through audit and service evaluation.

Therefore, the aim of this audit was to demonstrate occupational therapy outcomes in adult social care through use of the Therapy Outcome Measure findings. The objective was to determine if clients improved following occupational therapy

intervention in the four TOM domains of impairment, activity, participation and wellbeing/carer wellbeing from seventy TOM cases.

Ethical Considerations

Ethical approval was not required for this internal NHS Trust audit. Specialist services manager approval for the audit was obtained and a clinical audit registration form completed for the quality and patient safety audit lead for the Trust prior to commencement. The registration form was processed under a local scoring system to ensure high quality. The audit was approved as a quality improvement initiative as the TOM was new to the service, and re-auditing could be implemented.

Sampling

All clients seen by occupational therapy teams; major adaptations, short term assessment and reablement (STAR), Wirral independence service (equipment), and adult social care team are defined as the population. Between 40-70 records could be audited under the Trust quality and governance service. The audit purposively sampled 70 clients from October/September 2020 with finalised TOM scores included in the sample. Exclusion criteria comprised clients seen under the Independent Mobility Assessor service (blue badge), which was delivered through Wirral council, as this service was not running TOM.

Data Collection Method

The Therapy Outcome Measure records for clients were taken from the adult social care recording system “Liquid Logic” (<https://www.liquidlogic.co.uk/>) by a Trust information analyst. Records from client’s cases were examined from the end of October 2020, working backwards until beginning of September 2020 to identify the sample of 70 cases with an initial and final TOM score. TOM data was extracted from the occupational therapy activities of daily living, (ADL), manual handling, bed safety and seating assessment documents and a stand-alone TOM record document. TOM data was placed onto a excel spreadsheet for analysis.

A Trust audit report was produced by the quality review team and finalised by the author.

Results

Demographic results by sex show 46% (n=32) male and 54% (n=38) female. The range of medical conditions found is noted in Table 2; over half of sample had a musculoskeletal condition, plus over one third had a neurological condition and 60% of clients had multiple medical conditions. 3% had an unclear diagnosis or no condition. Age distribution is shown in table 3; 70% of the sample were over age 61 and a quarter were over age 81. Figure 1 displays the TOM adapted scales utilised by practitioners; most utilised was the multifactorial conditions scale which reflects the range of multiple conditions encountered. 94% of cases audited had a completed TOM score within a 2-week timeframe.

Medical Diagnosis	Number of clients n=70	%
Musculoskeletal	38	54
Neurological incl. stroke, epilepsy, brain injury	26	37
Heart	17	24
Respiratory	16	23
Visual Impairment	6	9
Mental Health	11	16
Learning Disability	4	6
Cancer	6	9
Amputee/reduced mobility	7	10
Dementia	5	7
Other incl. digestive condition, HIV/AIDS, Hearing impairment, tracheostomy, allergy, Asperger's/autism, liver disease.	9	13

Table 2. Range of Medical Conditions noted in sample

Table 3

Age	Count	%
18-30	1	1
31-40	3	4
41-50	7	10
51-60	11	16
61-70	17	24
71-80	13	19
81-90	14	20
90+	4	6
Total	70	100

Table 3. Age distribution of sample

Improvement

100% of clients showed an improvement or remained at the same level following occupational therapy intervention, in domains of impairment, participation and carer wellbeing. (Table 4). Notably, 55 clients improved in activity domain and 35 improved in wellbeing.

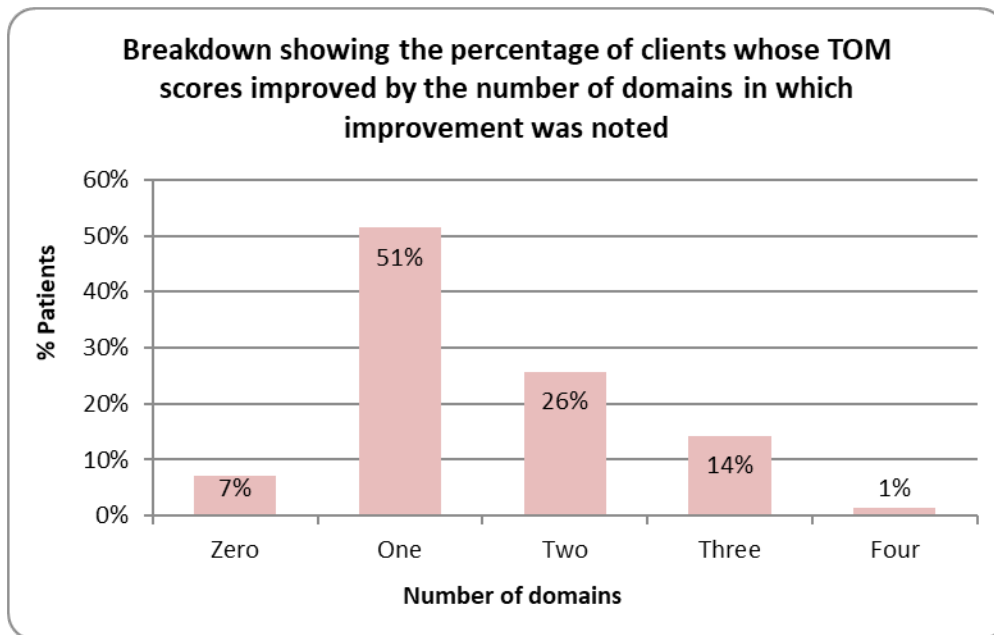
Table 4

Domain	Lower score	Same score	Higher score
Impairment	0	68	2
Activity	3	12	55
Participation	0	56	14
Wellbeing client	1	34	35
Wellbeing carer (n=14)	0	3	11

Table 4 Frequency of final TOM scores compared to original score.

Figure 2 demonstrates 94% of the sample showed an improvement in at least one domain, 40% showed an improvement in 2 or more domains. 1% showed an improvement in all 4 domains. (Figure 2). This is in line with expectations for the service which works with people with long-term conditions who are not expected demonstrate improvement in medical status.

Figure 2



The audit found that data could be extracted to show outcomes for clients with specific conditions as sufficient sample was identified. In this audit, clients with multiple long-term conditions (37/70), musculoskeletal (33/70) and mental health conditions (11/70) were specified. Improvement in at least one domain following occupational therapy occurred for the following client groups: those with multiple long-term conditions 92%, clients with musculoskeletal conditions 94% and clients with mental health conditions, 91%.

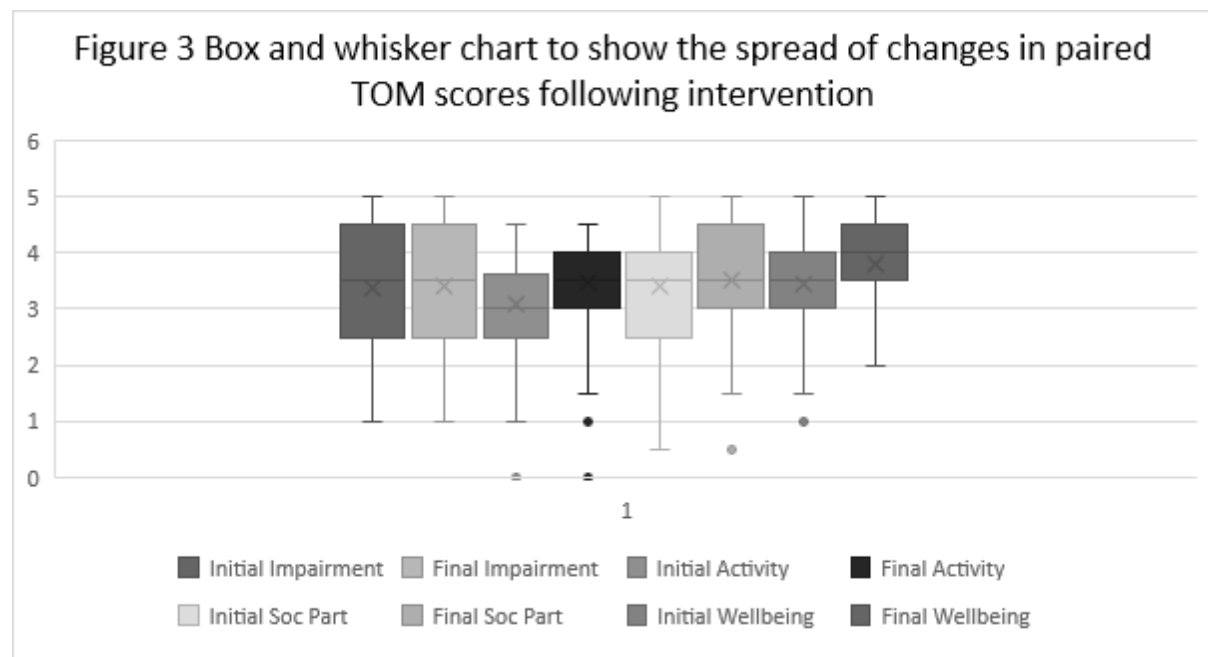
Deterioration

Three clients deteriorated in activity domain and one in wellbeing (table 4). Five clients did not show an improvement in any domain, (Figure 2) but of these 3 client's domain levels remained the same. Clients seen by this service may deteriorate in their impairment which may account for this result.

Impairment

A bar and whisker chart (figure 3) to show quartile distributions, indicates pre and post impairment scores were largely unchanged by occupational therapy. Impairment scores relate to body structures and functions for example cardiovascular, neurological, cognitive, respiratory. Occupational therapy in adult social care does not seek to provide direct medical intervention relating to bodily

impairment, as it is not a rehabilitation service and does not have a medical focus. The median for pre and post impairment scores is 3.5.



Activity

The TOM is based on the positive language of the ICF (WHO, ICF 2001). Under the ICF, disability is named activity and includes factors such as communication, movement, domestic and personal activities of daily living. These are relevant factors for intervention for occupational therapists. Activity is the degree to which a person's impairment affects their ability to perform a task or function compared to someone of the same age, sex and culture without the medical condition. In adult social care, an activity example could be a client's ability to manage independent bed mobility. A profound (0) score descriptor is unable to perform tasks/totally dependent on others, whereas a normal (5) score is age-appropriate ability to function/perform task. Figure 3 shows the spread of changes in pre and post activity scores. The median point for the pre activity score is 3, and post activity median is 3.5 which represents clinically significant change. The TOM core scale defines a level 3 activity function as "Can undertake task/function in familiar situation but requires some verbal/physical assistance." Twelve clients from the sample (Table 4) showed no improvement in activity domain score following occupational therapy intervention. Of this sample,

75% ($n=9$) improved in wellbeing client scores which demonstrates wider health impact.

Participation

The participation domain is concerned with the function of the client within their social context. It incorporates the amount of social participation, interaction, autonomy and control the client can exercise over their environment. In occupational therapy adult social care, participation could be the mental capacity to make a decision to opt for a stairlift to access essential toilet, bathing and bedroom facilities, rather than rehousing, taking all environmental, social and political factors into consideration. Participation can include a client's ability to work and participate in education and recreation. A profound (0) score descriptor would be isolated/no relationships/ no control. A normal (5) score descriptor is integrated and autonomous. A moderate (3) score would indicate a client can achieve some integration and has some control over life. The audit dataset results show 20% of client's participation scores improved, with the remaining 80% staying the same. The median participation pre-score and post score is 3.5 showing no clinically significant change.

Wellbeing Client

The wellbeing domain is scored for all clients in the service and is an optional score for carers as not all clients will be able to identify a carer. Figure 3 demonstrates the improvement noted in paired TOM client wellbeing scores. Wellbeing is associated with feelings and emotions, burdens of care, upset/anxiety/frustration/embarrassment/withdrawal and level of distress. Wellbeing/distress is measured in severity and frequency. A profound score (0) descriptor is a client or carer with constant levels of distress. A normal score (5) on the ordinal scale descriptor is a well-adjusted client/carers, stable and able to cope emotionally. A moderate score (3) is moderate and frequent levels of distress; client or carer can control emotions on some situations with support. In adult social care, wellbeing would be expected to improve for clients and carers following occupational therapy, due to the type of interventions given to relieve burdens. Examples include moving and handling advice and teaching, equipment provision, recommendations for assistive technology to maintain client safety in the home, or provision of rails to

reduce frequency of falls. Table 4 demonstrates 50% of client's wellbeing scores improved following occupational therapy. The median client wellbeing score is 3.5 and post score is 4, again showing clinically significant change. Further data analysis of the dataset showed impact for clients with mental health conditions, ($n=11$) 45% improved in their wellbeing following occupational therapy intervention with 55% remaining the same.

Wellbeing Carer

Figure 3 also indicates spread of changes in TOM paired scores for carer wellbeing. 11/70 cases showed a carer wellbeing score (16%), which indicates a small sample so should be interpreted with caution. The same TOM descriptors are used for the carer and client wellbeing scores. The service takes many referrals from formal and informal carers for collaborative moving and handling work, liaison with carers regarding major adaptation, seating provision and provision of minor equipment and adaptations plus assistive technology. The TOM carer domain on liquid logic is a non-mandatory recording field for practitioners as a carer is not always identified. 79% of sampled carer wellbeing scores improved following intervention (Table 4). The median pre carer wellbeing score was 3, and post score was 4 again displaying clinically significant change.

Discussion

The aim of this study was to demonstrate occupational therapy outcomes in adult social care through use of the Therapy Outcome Measure findings. Evidence from the data suggests that occupational therapy interventions make an impact for clients and carers in the four TOM domains of impairment, activity, participation and wellbeing/carer wellbeing in the adult social care setting. However, without controlling all variables it is difficult to purely attribute all change to occupational therapy. Using data from TOM allows associations between nature and type of services and use of benchmarking (Enderby *et al.*, 2003) across health and social care services can assist in making associations between relationships.

In integrated health and social care, clients will potentially receive involvement from GP, community nurse, physiotherapy, social work and other specialist services alongside the occupational therapist, which all contribute towards health and wellbeing. In many cases the TOM scores have resulted from collective interventions

for one activity, for example the assessment for and provision of moving and handling equipment (hoist, slings, profiling bed, slide sheets, sleep positioning aids), plus advice to formal and informal carers. It is also difficult to predict exact sustainability of changes identified in the data, as the nature of chronic disease may cause deterioration of function. However, the occupational therapist, within the adult social care role considers long term decline in their clinical decision making when making provisions. Occupational therapists in the team review provision of equipment if risk is high, for example stand aid hoists, and can note and compare the TOM score if deterioration is found.

The TOM is a quantitative measure and is therefore limited in retrieving the lived experience of the client/carer involved. Kelly *et al.*, (2020) describes the challenges to measuring integration which includes identification of an appropriate tool. Gaining the perspective of the person experiencing care (Crocker *et al.*, 2020) is recommended when selecting from the measures available. In this case the TOM was adopted as a pre-existing NHS approach to measuring outcomes and has been successfully utilised upon integration, aided by a cross-AHP TOM networking group. Shand and Turner (2019) promote this cross-sector collaboration to aid integration, plus inter-sector cooperation is key to sustainable change (Klinga *et al.*, 2018).

Adult social care is not a rehabilitative service, however frequent liaison with local rehab practitioners occurs who also score the TOM. Further challenges to recording or viewing other professionals TOM scores results from use of different electronic patient records within the same Trust.

The time interval of recording TOM reflects the speed which a practitioner can pick up a case, assess and make safe provision and follow up. The availability of occupational therapy support practitioners within the adult social care team supports the more rapid through put of straightforward cases where change can be quickly noted, whereas more complex and long-term work is assigned to qualified staff.

Impairment

Results from this audit showed that 97% of client's impairment levels remained the same or improved (3%), reflecting the remit of the service, which does not have a medical or rehabilitative focus. In social care settings, the focus of occupational therapy is often on maintenance of occupational performance rather than

improvement (Heaton and Bamford 2001). Incidentally, although the service works with people with deteriorating conditions, the audit sample did not identify a decrease across impairment scores, this potentially reflects the short episode (Sept/Oct 2020) of care within sample timeframe.

Occupational therapy philosophy is humanist, holistic and client centred (Finlay 2001), promoting a holistic model of health reaching beyond bodily functions and structures (impairment) alone. Change in the TOM impairment domain is unlikely compared to other domains, but its use demonstrates the holistic approach of occupational therapy, plus therapists should be rigorous in selecting a measure to ensure the “best fit” (Corr and Siddons 2005) as a single measure of health does not exist (Wade 2009).

Activity

Use of activity is a core tenet of occupational therapy philosophy which seeks to improve occupational performance: the doing of meaningful activities, and tasks through complex interaction between the person and the environment (Baum *et al.*, 2011). Use of equipment and adaptations supports essential activity, enabling clients to overcome barriers, which is the remit of the occupational therapy role in adult social care. The audit results show 79% of clients improved in the activity domain following occupational therapy intervention. The median point for the pre activity score is 3, and post activity median is 3.5, showing a small but clinically significant change (Enderby and John 2015) over the sample timeframe. Despite the small change, interventions for safe activities to enable occupational performance, such as equipment provision, is pivotal to enable and improve activity (Forsyth and Hamilton 2008), plus assistive technology can be prescribed (Mountain 2004) to enable activities and prevent falls.

Reablement is offered in the STAR team, however domain results were not available separately and cannot be differentiated to demonstrate STAR outcomes. The scope of reablement seeks to improve performance in daily activities (Francis *et al.*, 2011) and can promote independence and reduce re-referral (Littlechild *et al.*, 2010).

Participation

Enabling participation is a key focus of occupation for the therapist in adult social care. Practitioners aim to enable clients to engage in meaningful roles which support

their participation in everyday life (Christiansen and Baum 2005). The results show that just 20% (14/70) of client participation scores improved following intervention. Factors affecting this could be the impact of the covid-19 pandemic, due to self-isolating or shielding restrictions. Certainly, occupational deprivation (Whiteford 2000) caused by the pandemic has precluded both clients and staff from engaging in occupations, due to circumstances outside their control. However, occupational therapy assessments have continued throughout the pandemic whether virtual or in-person, where essential to view environments, fit equipment and continue with essential moving and handling “hands on” tasks.

Wellbeing Client and Carer

The occupational therapist in adult social care works to the Care Act (DHSC 2014) requiring the local authority to promote wellbeing. A close correlation between the philosophy of occupational therapists and the underpinning wellbeing principle of the Care Act (2014) exists. Wellbeing is a personally defined dynamic state and can be difficult to define such a subjective concept as each person will uniquely experience their own social, spiritual and cultural state of wellbeing (RCOT 2016). In the Care Act (2014), wellbeing relates to factors such as dignity, physical and mental health, protection from abuse and neglect, whilst the TOM uses frequency and severity of distress/upset/anger to stability to define wellbeing. The sample data demonstrates that 50% of clients showed an improvement or same level (49%) in client wellbeing, which indicates the positive impact the local occupational therapy service is making with its client group.

Despite the small sample of carer scores extracted from liquid logic, (11/70), 79% of carers showed an improvement in ‘carer wellbeing’ with 21% staying the same. Again, no deteriorations were noted in wellbeing, demonstrating the positive impact of the service. Following the audit, the carer sample data gap was addressed with the team and written instructions on liquid logic to promote collection of data on carer wellbeing was provided.

Limitations

The audit did not collect data on uptake from the separate teams (Equipment, housing, STAR and adult social care work) in occupational therapy adult social care. Potential sampling bias occurred as cases with completed scores only were

purposively sampled. Sampling was not random which prevented data gathering on uptake of TOM across the separate teams. Additionally, the audit results can only be applied to the setting from which the data was collected, so has limited external validity.

Action Plan following Audit

Following initial audit, several improvements were identified for the service which have been implemented. Firstly, revision of the participation domain was completed with the team to check understanding and clarify the scope of this domain. Secondly, additional wording added to the electronic TOM record in liquid logic system to capture more optional carer wellbeing measurements by practitioners. Thirdly, the “Trust Information Gateway” dashboard has been utilised to demonstrate TOM data per allied health service across the Trust, which further supports adult social care and NHS integration. The active use of an outcome measure will continue in line with RCOT (2021) guidance to inform practice and maintain quality.

Conclusion

The data gleaned from the audit of the Therapy Outcome Measure suggests occupational therapy in an adult social care setting, delivered in an integrated NHS Trust makes an impact with their client group and carers. Evidence from the TOM data demonstrates clinically significant change, as 93% of clients seen by adult social care occupational therapy staff showed an improvement in at least one therapy outcome measure domain during their whole episode of care. This study has illustrated a positive change in practice.

Recommendations for occupational therapy, adult social care service.

Continue to utilise the Therapy Outcome Measure to develop professional knowledge and confidence (Duncan and Murray 2012) and to record and demonstrate impact. Continue audit cycle as a quality improvement measure to determine if the changes implemented as a result of the initial audit have directly led to an improvement of care. Also, re-audit to randomly sample cases to explore uptake of TOM use across the teams. Explore if more carer data is available at re-audit following the re-wording on liquid logic system. At re-audit further explore deterioration rates in impairment domain. Continue for new staff to be trained in the

TOM and provide update sessions for existing staff. Continue to develop TOM use across the Trust with the local TOM AHP network meeting to share good practice.

References

Baum C, Christiansen C, Bass JL (2011) The Person-Environment-Occupational-Performance (PEOP) Model. In EAS Duncan ed. *Foundations for Practice in Occupational Therapy* London Elsevier

Bowling A (2009) *Research Methods in Health*. Maidenhead Open University Press

Bryman A (2008) *Social Research Methods*. 3rd Ed. Oxford. Oxford University Press

Buth S, D'Cruz L (2012) Clinical audit – Process and outcome for improved clinical practice. *Dental Update* December 2012 p710-714

Caldwell C, Twelvetree T, Cox D (2015) An evaluation of Therapy Outcome Measures (TOM) in community rehabilitation. *International Journal of Therapy and Rehabilitation* 22 (7) 310-319

Christiansen C, Baum CM (2005) The complexity of human occupation. In Christiansen CH, Baum CM, Bass-Haugen J (2005) *Occupational therapy: Performance, Participation and Well-being*. Thorofare NJ Slack

Corr S, Siddons L (2005) An introduction to the selection of outcome measures. *British Journal of Occupational Therapy* 68 (5) 202-206

CQC Care Quality Commission Available at <https://www.cqc.org.uk/> Accessed 14/04/2021

Coughlan C, Manek N, Razak Y, Klaber RE (2020) How to improve care across boundaries. *The BMJ* doi:1136/bmj.m1045

Crocker H, Kelly L, Harlock J, Fitzpatrick R, Peters M (2020) Measuring the benefits of the integration of health and social care: qualitative interviews with professional stakeholders and patient representatives BMC Health Services Research <https://doi.org/10.1186/s12913-020-05374-4> Accessed 6/7/21

Department of Health (2008) High Quality Care for All. NHS Next Stage Review Final Report Available at

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf Accessed 21/4/2021

Dept of Health and Social Care (2012) Health and Social Care Act Available at <https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> Accessed 21/4/21

Department of Health and Social Care (2014) Care Act Available at <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted> Accessed 09/04/2021

Dickinson H, O'Flynn J (2016) *Evaluating Outcomes in Health and Social Care* 2nd Edition Bristol Policy Press

Duncan EAS, Murray J (2012) The barriers and facilitators to routine outcome measurement by allied health professionals in practice: a systematic review. *BMC Health Services Research* 2012 12:96

Enderby P, John A, Hughes A, Petheram B (2003) Using benchmarking data for assessing performance in occupational therapy. *Clinical Governance: An International Journal*. 8 (4) 290-295

Enderby P, John A (2015) *Therapy Outcome Measures for Rehabilitation Professionals*. 3rd Edition Guildford J&R Press Ltd

Enderby P, John A (2019) *Therapy Outcome Measure User Guide and Scales*. Guildford J&R Press Ltd

Finlay L (2001) Holism in Occupational Therapy: Elusive Fiction and ambivalent struggle. *American Journal of Occupational Therapy* 55 (3) 268-276

Forsyth K, Hamilton E (2008) Social Services occupational therapists' views of practice and integration with health: a survey. *British Journal of Occupational Therapy* 71 (2) 64-71

Francis J, Fisher M, Rutter D (2011) Reablement: a cost-effective route to better outcomes. *Research Briefing* 36 London Social Care Institute for Excellence

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Stationary Office Available at <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry> Accessed 26/11/2020

Glasby J (2017) The holy grail of health and social care integration. The British Medical Journal 16 Feb 2017

Heaton J, Bamford C (2001) Assessing the outcomes of equipment and adaptations: issues and approaches *British Journal of Occupational Therapy* 64 (7) 346-356

Health and Care Professions Council Standards of Proficiency Occupational Therapists (2018) Available at <https://www.hcpc-uk.org/standards/standards-of-proficiency/occupational-therapists/> Accessed 09/04/2021

Kelly L, Harlock J, Peters M, Fitzpatrick R, Crocker H (2020) Measures for the integration of health and social care services for long-term health conditions: a systematic review of reviews. BMC Health Services Research <https://doi.org/10.1186/s12913-020-05206-5> Accessed 6/7/21

Klinga C, Hasson H, Sachs MA, Hansson J (2018) Understanding the dynamics of sustainable change: A 20-year case study of integrated health and social care. BMC Health Services Research <https://doi.org/10.1186/s12913-018-3061-6> Accessed 6/7/2021

Laver Fawcett AJ (2007) *Principles of Assessment for Occupational Therapists and Physiotherapists*. Chichester Wiley

Littlechild R, Bowl R, Matka E (2010) An independence at home service: the potential and pitfalls for occupational therapy services. *British Journal of Occupational Therapy* 73 (6) 242-250.

Liquid Logic available at <https://www.liquidlogic.co.uk/> accessed 6/7/21

Mountain G (2004) Using the evidence to develop quality assistive technology services. *Journal of Integrated Care* 12 (1) 19-26

NICE (National Institute for Clinical Excellence) pathway (2021) Peoples experience in adult social care services Available at

<https://pathways.nice.org.uk/pathways/peoples-experience-in-adult-social-care-services> Accessed 14 /04/2021

Pearson, B (2017) The clinical governance of multi-disciplinary care. *International Journal of Health Governance* 22 (4) 246-250

Peck E, Towell D, Gulliver P (2001) The meaning of culture in health and social care: a case study of the combined trust in Somerset. *Journal of Interprofessional Care* 15 (4) 319-327

Royal College of Occupational Therapists (2015) Measuring Outcomes Research Briefing. London RCOT Available at <https://www.rcot.co.uk/sites/default/files/Research-Briefing-Measuring-Outcomes-Nov2015.pdf> Accessed 09/04/2021

RCOT (2016) Care Act 2014 Guidance for Occupational Therapists Wellbeing London RCOT Available at <https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/care-act-2014-wellbeing> Accessed 23/4/2021

Royal College of Occupational Therapists (2021) Professional standards for occupational therapy practice, conduct and ethics. London RCOT Available at <https://www.rcot.co.uk/publications/professional-standards-occupational-therapy-practice-conduct-and-ethics> Accessed 09/04/2021

Shand J, Turner S (2019) System Wide Collaboration? Health and social care leaders' perspectives on working across boundaries. *Journal of Integrated Care* 27 (1) 83-94

Unsworth C (2000) Measuring the outcome of occupational therapy: Tools and resources. *Australian Occupational Therapy Journal* 47 147-158

Wade D (2009) Generic or global outcome measures in rehabilitation: are they appropriate for measuring and improving service quality? *Clinical Rehabilitation* 23:867-872

Whiteford G (2000) Occupational deprivation: Global challenge in the new millennium *British Journal of Occupational Therapy* 63 (5) 200-204

Whittaker A, Williamson GR (2011) *Succeeding in Research Project Plans and Literature Reviews for Nursing Students*. Exeter Learning Matters

World Health Organisation (2001) International Classification of Functioning, Disability and Health Available at <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health> Accessed 09/04/2021